

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/24/2012
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 N RITTER AVE INDIANAPOLIS, IN 46219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for a State complaint survey.</p> <p>Complaint Number: IN00100032 Unsubstantiated; allegation did not occur</p> <p>Survey Date: 1-26-12</p> <p>Facility Number: 005068</p> <p>Surveyor: Jack I. Cohen, MHA Medical Surveyor</p> <p>Community Hospital East was found in compliance with the 410 IAC 15-1.5-2, Infection control and 15-1.5-8, Physical plant, environment and maintenance requirements for licensure rules.</p> <p>QA: claughlin 02/17/12</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

VTR411

If continuation sheet 1 of 1